		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001099

Facility Name: HILLCREST HOME

Address: 14688 ILLINOIS HIGHWAY 82 (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (309) 944-2147 **Fax #** (309) 944-8417

IDPA ID Number: 36-6001257001

Date of Initial License for Current Owners: 06/10/56

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JAMES E. TAYLOR **Telephone Number:** (309) 762-3626

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/04 to 11/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARY BERGREN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) JAMES E. TAYLOR, MEMBER
(Firm Name & Address) CARPENTIER, MITCHELL, GODDARD & CO., LLC, 4915 21ST AVENUE A, MOLINE, IL 61265
(Telephone) (309) 762-3626 Fax # (309) 762-4465

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 05/16/05

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	0	12,284	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	106	50,974	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	772	1,695		2,467	8
9	SNF/PED					9
10	ICF	19,256	13,664		32,920	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,028	15,359		35,387	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.42%

D. How many bed-hold days during this year were paid by the Department? 82 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/10/53

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 2,019

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/05 Fiscal Year: 11/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	295,081	15,214	7,723	318,018		318,018		318,018			1
2	Food Purchase		151,840		151,840		151,840	(597)	151,243			2
3	Housekeeping	118,513	4,867	944	124,324		124,324		124,324			3
4	Laundry	96,819	10,021	1,091	107,931		107,931		107,931			4
5	Heat and Other Utilities			153,500	153,500		153,500	(5,919)	147,581			5
6	Maintenance	90,928	11,865	49,212	152,005		152,005		152,005			6
7	Other (specify):*											7
8	**TOTAL General Services**	601,341	193,807	212,470	1,007,618		1,007,618	(6,516)	1,001,102			8
	B. Health Care and Programs											
9	Medical Director			600	600		600		600			9
10	Nursing and Medical Records	1,685,331	152,147	80,611	1,918,089		1,918,089	(7,786)	1,910,303			10
10a	Therapy	51,986	135	213,380	265,501		265,501	(406,844)	(141,343)			10a
11	Activities	49,613	2,693	31	52,337		52,337	(926)	51,411			11
12	Social Services	55,885	28	1,577	57,490		57,490		57,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,842,815	155,003	296,199	2,294,017		2,294,017	(415,556)	1,878,461			16
	C. General Administration											
17	Administrative	61,668			61,668		61,668		61,668			17
18	Directors Fees											18
19	Professional Services			7,170	7,170		7,170		7,170			19
20	Dues, Fees, Subscriptions & Promotions			19,368	19,368		19,368	(6,377)	12,991			20
21	Clerical & General Office Expenses	126,091	5,635	36,166	167,892		167,892	(10,827)	157,065			21
22	Employee Benefits & Payroll Taxes			771,767	771,767		771,767	(2,997)	768,770			22
23	Inservice Training & Education			1,109	1,109		1,109		1,109			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,434	65,434		65,434		65,434			26
27	Other (specify):*											27
28	**TOTAL General Administration**	187,759	5,635	901,014	1,094,408		1,094,408	(20,201)	1,074,207			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,631,915	354,445	1,409,683	4,396,043		4,396,043	(442,273)	3,953,770			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLCREST HOME #0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			229,581	229,581		229,581	(39,411)	190,170			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,581	229,581		229,581	(39,411)	190,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,014	2,014		2,014	(1,411)	603			38
39	Ancillary Service Centers			301,836	301,836		301,836	(84,250)	217,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		4,211		4,211		4,211	(4,211)				41
42	Provider Participation Fee			76,461	76,461		76,461		76,461			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		4,211	380,311	384,522		384,522	(89,872)	294,650			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,631,915	358,656	2,019,575	5,010,146		5,010,146	(571,556)	4,438,590			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(597)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,919)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,997)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,762)	21		24
25	Fund Raising, Advertising and Promotional	(6,377)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(544,904)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (571,556)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (571,556)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HILLCREST HOME

ID# 0001099

Report Period Beginning: 12/01/04

Ending: 11/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MEDICARE REIMBURSEMENTS	$ (84,250)	39	1
2	TELEPHONE CALLS CHARGED TO PATIENTS	(65)	21	2
3	TRANSPORTATION	(1,411)	38	3
4	OXYGEN REIMBURSEMENT	(7,786)	10	4
5	ACTIVITIES FEES	(926)	11	5
6	THERAPY REIMBURSEMENTS	(406,844)	10A	6
7	VENDING MACHINE	(4,211)	41	7
8	DEPRECIATION ADJUSTMENT	(39,411)	30	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(544,904)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(597)	0	0	0	0	0	0	0	0	0	0	(597)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,919)	0	0	0	0	0	0	0	0	0	0	(5,919)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,516)	0	0	0	0	0	0	0	0	0	0	(6,516)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7,786)	0	0	0	0	0	0	0	0	0	0	(7,786)	10
10a	Therapy	(406,844)	0	0	0	0	0	0	0	0	0	0	(406,844)	10a
11	Activities	(926)	0	0	0	0	0	0	0	0	0	0	(926)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(415,556)	0	0	0	0	0	0	0	0	0	0	(415,556)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,377)	0	0	0	0	0	0	0	0	0	0	(6,377)	20
21	Clerical & General Office Expenses	(10,827)	0	0	0	0	0	0	0	0	0	0	(10,827)	21
22	Employee Benefits & Payroll Taxes	(2,997)	0	0	0	0	0	0	0	0	0	0	(2,997)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,201)	0	0	0	0	0	0	0	0	0	0	(20,201)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(442,273)	0	0	0	0	0	0	0	0	0	0	(442,273)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number HILLCREST HOME **#** 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(39,411)	0	0	0	0	0	0	0	0	0	0	(39,411)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,411)	0	0	0	0	0	0	0	0	0	0	(39,411)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,411)	0	0	0	0	0	0	0	0	0	0	(1,411)	38
39	Ancillary Service Centers	(84,250)	0	0	0	0	0	0	0	0	0	0	(84,250)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(4,211)	0	0	0	0	0	0	0	0	0	0	(4,211)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(89,872)	0	0	0	0	0	0	0	0	0	0	(89,872)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(571,556)	0	0	0	0	0	0	0	0	0	0	(571,556)	45

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HENRY COUNTY, ILLINOIS	100	NONE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLCREST HOME **#** 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	N/A	8
	2001	N/A	9
	2002	N/A	10
	2003	N/A	11
	2004	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HOME COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0001099

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,394 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	6 ACRES	VARIOUS	$ 1,000	1
2					2
3	TOTALS	#VALUE!		$ 1,000	3

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1971	1971	$ 220,795	$ 4,415	50	$ 4,415	$	$ 146,940	4
5	22		1976	1976	1,064,182	21,285	50	21,285		633,692	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1977	52,950	1,059	50	1,059		30,711	9
10	GENERAL			1979	6,552		3			6,552	10
11	GENERAL			1980	14,609	292	50	292		7,450	11
12	GENERAL			1981	61,074	1,222	50	1,222		29,925	12
13	GENERAL			1982	6,189		3			6,189	13
14	GENERAL			1983	79,248	1,317	.10-50	1,317		48,058	14
15	GENERAL			1984	46,106	848	.10-50	848		21,946	15
16	GENERAL			1985	76,531	1,692	.20-30	1,692		40,795	16
17	GENERAL			1986	76,930	2,612	.20-30	2,612		52,070	17
18	GENERAL			1987	120,391	4,013	30	4,013		75,995	18
19	GENERAL			1988	70,622	2,000	.12-40	2,000		38,147	19
20	GENERAL			1989	209,235	7,378	.20-40	7,378		121,519	20
21	GENERAL			1990	810,969	27,032	30	27,032		572,849	21
22	GENERAL			1991	336,390	11,213	30	11,213		233,001	22
23	GENERAL			1992	121,611	5,922	.5-20	5,922		83,118	23
24	GENERAL			1993	57,379	1,582	.5-20	1,582		40,827	24
25	GENERAL			1994	106,380	4,921	.10-20	4,921		69,381	25
26	GENERAL			1995	106,336	4,592	.10-40	4,592		51,937	26
27	RECOAT ROOF			1996	2,495	125	20	125		1,154	27
28	LIGHT FIXTURES			1996	1,855	185	10	185		1,763	28
29	HAND RAILS			1996	1,669		5			1,669	29
30	TUCK POINTING			1996	8,272	414	20	414		3,964	30
31	GARAGE			1997	5,708	143	40	143		1,196	31
32	AIR CONDITIONING			1997	35,751	1,787	20	1,787		14,747	32
33	COOLER			1997	18,258	913	20	913		8,064	33
34	BUILDING LIGHTS			1997	1,517		5			1,517	34
35	ROOF			1997	4,620	154	30	154		1,309	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PUMP HOUSE REPAIRS	1997	$ 800	$ 40	20	$ 40	$	$ 353	37
38	EXPAND LAGOON SYSTEM	1998	370,488	12,350	30	12,350		108,059	38
39	BOILER REPAIRS	1998	1,649	165	10	165		1,154	39
40	WATER HEATER	1998	3,550	355	10	355		2,781	40
41	ROOF	1998	5,477	274	20	274		2,054	41
42	GUTTERS	1998	5,767	289	20	289		2,283	42
43	EXPAND LAGOON SYSTEM	1999	46,155	2,307	20	2,307		14,401	43
44	BOILER REPAIRS	1999	23,138	2,314	10	2,314		13,883	44
45	HEATING MOTOR	1999	3,000	300	10	300		2,000	45
46	PARKING LOT LIGHTS	1999	1,284	129	10	129		899	46
47	CARPET	2000	2,626	262	10	262		1,378	47
48	WATER LINE REPAIR	2000	620	62	10	62		326	48
49	REFURBISH WASHERS	2000	3,168	317	10	317		1,769	49
50	A/C REPAIR	2000	6,781	678	10	678		3,729	50
51	WATER HEATER REPAIR	2000	5,425	542	10	542		3,119	51
52	REMODELING	2001	8,630	432	20	432		2,014	52
53	CONCRETE WORK	2001	1,512	151	10	151		617	53
54	GAS LINE REPAIR	2001	21,529	2,153	10	2,153		9,509	54
55	A/C REFURBISH	2001	4,169	417	10	417		1,946	55
56	HEAT REFURBISH	2001	7,859	786	10	786		3,537	56
57	WATER HEATER	2001	6,488	649	10	649		2,974	57
58	WATER HEATER	2001	5,551	555	10	555		2,683	58
59	A/C REFURBISH	2002	8,661	866	10	866		3,031	59
60	HEATER REFURBISH	2002	6,994	699	10	699		2,448	60
61	WATER HEATER	2002	2,562	256	10	256		811	61
62	SATELITTE	2002	14,037	1,404	10	1,404		4,562	62
63	IRON PUMP	2002	1,386	138	10	138		554	63
64	SHOWER ROOM REPAIR	2002	3,096	310	10	310		1,213	64
65	KITCHENETTE ADDITIONS	2002	2,270	227	10	227		889	65
66	KITCHENETTE ADDITIONS	2002	4,021	402	10	402		1,407	66
67	GARAGE PAINTING	2002	1,670	167	10	167		557	67
68	HOUSEKEEPING OFFICE ADDITIONS	2002	2,161	216	10	216		810	68
69	PRIVATE ROOMS REPAIR	2002	7,441	745	10	745		2,605	69
70	TOTAL (lines 4 thru 69)		$ 4,314,589	$ 138,073		$ 138,073	$	$ 2,546,840	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,314,589	$ 138,073		$ 138,073	$	$ 2,546,840	1
2	WHIRLPOOL SYSTEM	2003	10,311	1,031	10	1,031		2,750	2
3	ELEVATOR REPAIR	2003	3,300	330	10	330		825	3
4	SATELLITE	2003	500	50	10	50		121	4
5	BUILDING SHUTTERS	2003	872	87	10	87		196	5
6	BLACKTOP DRIVEWAY	2003	9,887	989	10	989		2,307	6
7	PERGOLA ENTRYWAY	2003	3,433	344	10	344		830	7
8	REFURBISH RESIDENTS ROOMS	2003	15,698	1,570	10	1,570		3,401	8
9	A/C & HEAT REPAIR	2003	1,000	100	10	100		233	9
10	REFURBISH HEAT & A/C	2003	17,570	1,757	10	1,757		4,539	10
11	REMODEL SMOKING ROOMS	2003	9,131	913	10	913		2,511	11
12	PARKER TUB	2004	500	50	10	50		100	12
13	BRICKS FOR SIGN	2004	675	68	10	68		135	13
14	LANDSCAPING	2004	966	97	10	97		145	14
15	3D LETTERS FOR SIGN	2004	793	79	10	79		112	15
16	FIRE & SMOKE DAMPERS	2004	3,717	372	10	372		527	16
17	WELL PUMP	2004	3,043	304	10	304		431	17
18	TRANSFER SWITCH	2004	514	52	10	52		69	18
19	SE SITTING ROOM	2004	2,634	263	10	263		329	19
20	KITCHEN LIGHTS	2004	2,209	220	10	220		423	20
21	RESIDENTIAL BATHROOMS	2004	10,300	1,030	10	1,030		1,888	21
22	SMOKE DAMPERS TEST STATION	2004	1,127	112	10	112		197	22
23	PAINTING	2004	4,522	452	10	452		565	23
24	SCREENHOUSE	2004	1,682	168	10	168		210	24
25	LAUNDRY PROJECT	2004	3,455	346	10	346		576	25
26	BOILER REPLACEMENT	2004	17,001	1,700	10	1,700		2,975	26
27	NW MECHANICAL ROOM A/C	2004	4,516	451	10	451		602	27
28	SOUTH LINEN ROOM RENOVATION	2004	1,968	197	10	197		295	28
29	EXIT LIGHTS	2004	2,023	202	10	202		371	29
30	TRANSFER SWITCH	2004	3,946	394	10	394		526	30
31	ROOF REPAIR	2004	2,394	239	10	239		399	31
32	NORTHWEST WORK	2005	102	7	10	7		7	32
33	CEMETERY FENCE	2005	2,784	116	10	116		116	33
34	TOTAL (lines 1 thru 33)		$ 4,457,162	$ 152,163		$ 152,163	$	$ 2,575,551	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,457,162	$ 152,163		$ 152,163	$	$ 2,575,551	1
2	WELL PROJECT	2005	17,949	747	10	747		747	2
3	CEMETERY FENCE	2005	2,784	93	10	93		93	3
4	BEAUTY SHOP	2005	927	2	10	2		2	4
5	BRICK	2005	150	4	10	4		4	5
6	CEMENT PADS	2005	3,550		10				6
7	NEW LOUNGE HOURS SIGN	2005	3,142		10				7
8	BEAUTY SHOP HOURS SIGN	2005	2,650		10				8
9	NW NURSE STN HOURS SIGN	2005	9,030		10				9
10	BASEMENT OFFICE HOURS SIGN	2005	2,610		10				10
11	RESIDENT ROOM HOURS SIGN	2005	1,704		10				11
12	EAST SHOWER HOURS SIGN	2005	530		10				12
13	HEATERS	2005	7,172		10				13
14	DISHWASHER	2005	2,180		10				14
15	COOLERS	2005	2,597		10				15
16	BREAKROOM	2005	3,267		10				16
17	ROOF REPAIRS	2005	1,642		10				17
18	NORTHWEST WORK	2005	2,319		10				18
19	WATER HEATER	2005	4,799		10				19
20	SHOP PROJECT	2005	3,965		10				20
21	NW NURSE STATION	2005	851		10				21
22	BUILDING REPAIR - ASBESTOS STUDY	2005	5,450	182	10	182		182	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,536,430	$ 153,191		$ 153,191	$	$ 2,576,579	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 310,193	$ 30,276	$ 30,276	$		$ 144,271	71
72	Current Year Purchases	17,549	822	822			822	72
73	Fully Depreciated Assets	712,562					712,562	73
74								74
75	TOTALS	$ 1,040,304	$ 31,098	$ 31,098	$		$ 857,655	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORT	1996 CHEVY VAN	1996	$ 34,005	$	$	$		$ 34,005	76
77	PATIENT TRANSPORT	2001 DODGE CARAVAN	2003	25,000	5,000	5,000		5	10,417	77
78	PATIENT TRANSPORT	2001 DODGE VAN	2005	10,575	881	881		10	881	78
79										79
80	TOTALS			$ 69,580	$ 5,881	$ 5,881	$		$ 45,303	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,647,314	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,170	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,170	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,479,537	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	91 LUMINA/1991	$ 11,952	$	$ 11,952	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 11,952	$	$ 11,952	91

G. Construction-in-Progress

	Description	Cost	
92	SHOP ADDITION	$ 920	92
93			93
94			94
95		$ 920	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
   This amount was calculated by dividing the total amount to be amortized ____
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,442,812	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,000)	485,985		3
4	Supply Inventory (priced at)	27,209		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	2,176		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,958,182	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000		13
14	Buildings, at Historical Cost	5,303,678		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,121,836		16
17	Accumulated Depreciation (book methods)	(4,004,114)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,422,400	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,380,582	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,507	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,841		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 238,348	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 238,348	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,142,234	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,380,582	$	48

***(See instructions.)**

HILLCREST HOME
ID #0001099

YEAR ENDED 11/30/05

SCHEDULE XV - BALANCE SHEET

LINE 9 - OTHER CURRENT ASSETS

	AMOUNT
PREPAID EXPENSE	1748
ACCRUED INTEREST	428
TOTAL	2176

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,160,170	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,160,170	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(558,267)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (558,267)	17	
	B. Transfers (Itemize):			
18	**FICA REIMBURSEMENT**	197,739	18	
19	**IMRF REIMBURSEMENT**	177,136	19	
20	**INSURANCE REIMBURSEMENT**	159,658	20	
21	**OTHER REIMBURSEMENT**	5,798	21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 540,331	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,142,234	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,855,829	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,855,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	406,844	6
7	Oxygen	7,786	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 414,630	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	597	14
15	Telephone, Television and Radio	65	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 662	23
	D. Non-Operating Revenue		
24	Contributions	8,315	24
25	Interest and Other Investment Income***	28,154	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,469	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED SCHEDULE	144,289	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 144,289	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,451,879	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,007,618	31
32	Health Care	2,294,017	32
33	General Administration	1,094,408	33
	B. Capital Expense		
34	Ownership	229,581	34
	C. Ancillary Expense		
35	Special Cost Centers	308,061	35
36	Provider Participation Fee	76,461	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,010,146	40
41	**Income before Income Taxes (line 30 minus line 40)****	(558,267)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (558,267)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

HILLCREST HOME
ID #0001099

YEAR ENDED 11/30/05

SCHEDULE XVII - INCOME STATEMENT

E. OTHER REVENUE

	AMOUNT
MEDICARE PHARMACY PART A	75,783
MEDICARE LAB	4,318
MEDICARE RADIOLOGY	751
MEDICARE ME SUPPLIES PART A	3,398
VENDING MACHINE	9,032
NURSING SUPPLIES	28,717
TRANSPORTATION	1,411
ACTIVITIES FEES	926
MISCELLANEOUS	11,300
GAIN ON FIXED ASSET SALE	8,653
TOTAL	144,289

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,664	2,080	$ 59,042	$ 28.39	1
2	Assistant Director of Nursing	1,786	2,080	54,442	26.17	2
3	Registered Nurses	7,755	9,673	205,478	21.24	3
4	Licensed Practical Nurses	26,480	31,250	490,819	15.71	4
5	CNAs & Orderlies	74,362	85,760	840,022	9.80	5
6	CNA Trainees	1,137	1,293	11,167	8.64	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,776	2,080	51,986	24.99	8
9	Activity Director					9
10	Activity Assistants	4,782	5,476	49,613	9.06	10
11	Social Service Workers	3,503	4,108	55,885	13.60	11
12	Dietician					12
13	Food Service Supervisor	1,776	2,080	41,305	19.86	13
14	Head Cook	3,308	4,192	41,917	10.00	14
15	Cook Helpers/Assistants	21,284	24,054	211,858	8.81	15
16	Dishwashers					16
17	Maintenance Workers	7,962	9,476	90,928	9.60	17
18	Housekeepers	11,067	12,586	118,513	9.42	18
19	Laundry	9,000	10,400	96,819	9.31	19
20	Administrator	1,784	2,080	61,668	29.65	20
21	Assistant Administrator					21
22	Other Administrative	8,226	9,749	126,091	12.93	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,710	2,080	24,362	11.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,362	220,497	$ 2,631,915 *	$ 11.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	148	$ 6,239		35
36	Medical Director	6	600		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	1,220		45
46	Other(specify)				46
47	WASTE TREATMENT PLANT	48	3,000		47
48	WATER TREATMENT	48	2,928		48
49	TOTAL (lines 35 - 48)	314	$ 14,587		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	56	$ 1,969	10-3	50
51	Licensed Practical Nurses	1,648	52,129	10-3	51
52	Certified Nurse Assistants/Aides	972	19,980	10-3	52
53	TOTAL (lines 50 - 52)	2,676	$ 74,078		53

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY BERGREN		0	$ 61,668
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,668

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CMG & COMPANY	COST REPORT/AUDIT	$ 5,850
CLAUDON, KOST, BARNHART	LEGAL FEES	540
STATE'S ATTORNEY	LEGAL FEES	780
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,170

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,224
Unemployment Compensation Insurance	
FICA Taxes	197,739
Employee Health Insurance	299,639
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	177,136
PHYSICALS	25
LABORATORY WORK	7
EMPLOYEE RECOGNITION	2,997
LESS: ENTERTAINMENT	(2,997)
TOTAL (agree to Schedule V, line 22, col.8)	$ 768,770

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,674
Health Care Worker Background Check	
(Indicate # of checks performed 63)	630
PUBLIC RELATIONS	6,377
DUES & SUBSCRIPTIONS	7,687
Less: Public Relations Expense	(1,201)
Non-allowable advertising	(5,176)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,991

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/04 Ending: 11/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/04 **Ending:** 11/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **COUNTY NURSING HOME ASSN - $1040**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,567** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,461**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **597**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CARPENTIER, MITCHELL, GODDARD & CO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT APPROVED IN MAY**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.